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Civil Aviation Medical Association

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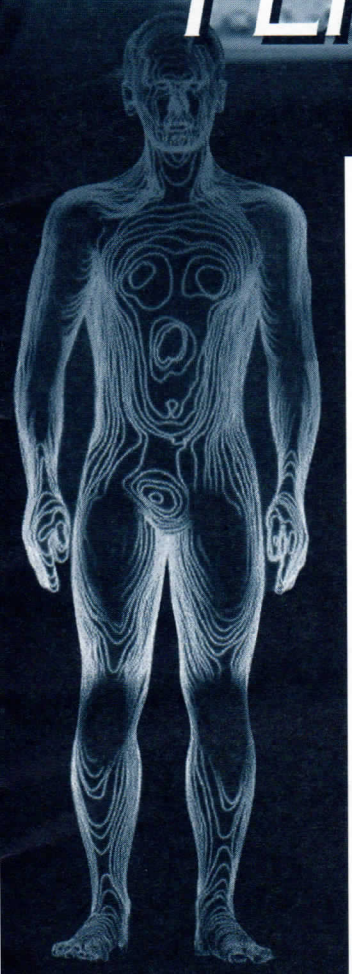

In This Issue

CAMA in Charleston for FAA Recertification Seminar

CAMA to hold one day seminar & social outing prior to FAA meeting

Under the program direction of Dr. David Millett, regional Flight Surgeon for the Southern Region and long-time CAMA Trustee, CAMA will hold a half-day seminar on Thursday October 28 with social activities planned for that afternoon and evening. The FAA seminar begins on Friday October 29 through Sunday morning October 31. CAMA is also planning a social event one evening (Friday or Saturday) during the FAA seminar. The final agenda has not been decided upon but there will be a demonstration of the new on board automatic external defibrillators and medical kits.

If you are due for AME recertification by the FAA then this would be a perfect match. Plan on being one day early and enjoy an interesting CAMA program. The social program will assure that you see firsthand why Charleston is unique as a truly authentic "southern hospitality" city. Watch your mail for registration information. And for you AME's that are not yet members of CAMA, this would be the perfect chance to learn why our membership has doubled over the last 3 years.

Conde' Nast Traveler named Charleston one of the top ten domestic destinations. Indeed , Charleston is known as America's most beautifully preserved architectural and historic treasures. The city was founded in 1670. This is a "see and do" city with extraordinary diversity. The International airport assures visitors of an easy arrival and departure. The southern and continental cuisine make Charleston a culinary center.

Selected sites: Fort Sumter, where the civil war began. The USS Yorktown, The Congressional Medal Of Honor Museum, Charleston's own musical variety show SERENADE.

Dining: 82QUEEN, fancy, fine and famous, The Wreck of Richard and Charlene, A real dump but the best fried seafood anywhere! Peninsula Grill, In the historic Planter's Inn, Beautiful and breathtaking. Louis's Restaurant and Bar, Expensive, beautiful decor, great food.

We hope you can join us in Charleston... You'll be glad you did!

SV

The President's Desk

John D. Hastings, M.D.

As I near the end of my term as president of CAMA, I have been reflecting on my years with this organization. When Jim Harris took the reigns as Executive Director in 1990, CAMA was struggling to survive with fewer than 200 members. Many of you, along with me, were called upon by Jim to meet and deliberate CAMA's future. We hammered out a plan for an organizational structure with vice presidents, committee chairpersons, and committee members. We set goals and initiated projects. We met, planned and revised plans.

Now as we approach the millenium CAMA membership is over 750 strong and growing. We can be proud of our accomplishments and successes. The old CAMA Bulletin was transformed into the new FlightPhysician under the able direction of your editor and president-elect, Stacy Vereen. Thanks to Robin Dodge, we have our own new website, which Robin continues to develop.

We have held a highly successful international meeting at Innsbruck, Austria, and international meetings are planned at three-year intervals. We now offer free membership to newly designated AME's in the initial year of designation.

We have joined forces with the FAA Office of Aviation Medicine in dealing with problem areas in aeromedical certification. We have strengthened our relationship with the Aerospace Medical Association (AsMA), participating on task forces dealing with airline medical kits and alternative medicine. This coming September we will take part in a second one-day seminar with AsMA, CAMA, and AMSUS (military flight surgeons), to be held in Washington, D.C.

We are exploring other joint efforts with AsMA including cross-recruiting efforts and co-hosting a function at the annual AsMA meeting for international members. We have developed a CAMA Consult program to help newly designated and less experienced AME's with problem medical certification. We have developed relationships with aviation organizations including the Experimental Aircraft Association and Aircraft Owners and Pilots Association, contributing speakers for medical programs at aviation gatherings.

We can indeed be proud of our accomplishments since we met in Oklahoma City in November 1990. Our work is not yet done. To nurture FlightPhysician, we need willing and able associate editors. Robin needs help in developing the web site. We need early and watchful guidance in developing our annual scientific program and international meetings. We must attend to membership.

We must keep abreast of issues and offer timely and responsible comment. We must represent CAMA in the aviation community.

CAMA has grown. For CAMA to flourish we need more than a few who are willing to nurture CAMA. We must identify members, both new and experienced, who are willing to contribute to CAMA, utilizing their talents and enthusiasm to move CAMA forward. Considering the busy lives of our members and the volunteer nature of our organization, this is not an easy task. I feel it is essential to expand the core group of individual CAMA members who contribute to the day-to-day operations of our organization.

Through sharing of responsibility and effort, we can sustain CAMA and look to its future.

Please join our Canadian colleagues and us this September in Toronto. I think it will be a great meeting, a fun time and a wonderful opportunity to see each other.

FLIGHTPHYSICIAN

A Publication of the Civil Aviation Medical Association (CAMA)

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Editorial

H. Stacy Vereen, M.D.

As we go about our everyday certification business, most of us realize that we serve an important gatekeeper function. If there was no requirement for a medical exam then most of us could surely recall an example or two of pilots that would be flying who should not be flying. There are other examples of pilots that were stopped at the gate for only a moment to adjust a parameter or two. A new pair of glasses, an adjustment in a blood pressure medication or advice on an acceptable medication for allergic rhinitis; these are all examples of routine gatekeeper activities.

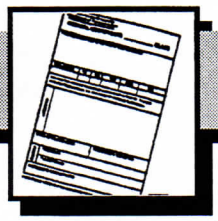
There are those that strongly disagree with the present system. Since 99+% of all applicants are ultimately certified, this cumbersome medical certification system is simply not worth the resources, they say. The system gets more cumbersome all the time. As the FAA continues to modernize and streamline, they are also considering more and more airmen with more and more conditions and diseases for certification. This, of course, leads to more and more review and more stringent follow-up protocols for these "borderline airmen". The pilot community perceives this as more work and bureaucratic hoopla for the hapless airman that happens to have a problem.

I don't think that I have ever met an airman that was overly concerned about the increased workload for the FAA due to the liberalization of policy in favor of certification. Maybe this perception is helped along by the AME. In an effort to side with "his" airman, maybe it's easier for the AME to agree with the him that the system is unfair to the airman and that the FAA is merely a bureaucratic barrier between him and his right to fly.

On the other hand, it often takes a massive amount of testing and documentation (and hence a massive amount of time consuming review) to be able to allow an airman fly under the special issuance provisions of Part 67. "No one loves flying half so much as the grounded pilot" so any delay in certification is painful to the airman and we, as AME's, would be less than empathetic were we not to side with our grounded airman.

Maybe all of us would be better served by using our best efforts to gently and compassionately educate the airman on how the review process works and how, by its very nature, it is a deliberate, time-consuming process. The FAA has one of the most liberal certification systems in the world. Many an airman unhappy about how long it took to get his ticket would, in many other countries, have been permanently grounded with no chance for recertification at all.

Hands on Certification



Highlights of the FAA's Medical Certificate Application Form From a Legal Perspective

Kathleen A. Yodice, Esq.

As it pertains to aviation medical certification, Congress gave the Administrator of the Federal Aviation Administration (FAA) the authority to prescribe minimum standards that the Administrator finds necessary for safety in air commerce. The FAA adopted minimum medical standards and codified them in Part 67 of the Federal Aviation Regulations. Congress also gave the FAA the authority to issue airman medical certificates to those individuals who meet the minimum safety standards. The FAA may only issue medical certificates to these individuals after an investigation has been conducted to determine the applicant's eligibility for the certificate. The FAA has long recognized it did not have the human resources to be able to perform the necessary investigation into each individual applying for an airman medical certificate without some assistance. Therefore, they chose to delegate some of the investigative and decision making authority to qualified physicians, who are given designations as Aviation Medical Examiners (AMEs).

The AME acts on behalf of the FAA in conducting the initial investigation into an applicant's medical qualifications. This is accomplished through a paper process as well as a physical examination. Experience has shown us that it is the paper process that carries with it the most serious medical and legal ramifications. The AME plays an important role in these issues, and it is imperative that he fully understands them in order to provide assistance to the applicant and to appropriately meet the responsibilities of his designation as an aviation medical examiner.

It is the paper process that carries with it the most serious medical and legal ramifications.

As part of the medical examination process, the applicant for an airman medical certificate must complete the front of the medical application, FAA Form 8500. The AME must complete the back of the same medical application form as it relates to the medical examination. There is an instruction sheet attached to each application form that is intended to provide guidance to the applicant in filling out the front of the form. This instruction sheet should not be torn off prior to giving the applicant the form to complete. In many cases, the instructions will assist the airman in accurately answering the medical questions. Without the benefit of the instruction sheet, the airman may guess at an answer and inadvertently cause the FAA to believe that the applicant intentionally falsified the answer. In any case, if you don't give an airman the instruction sheet, then if problems arise with the application, the AME could potentially be drawn into the situation. Protect yourself, give all airman applicants the instruction sheet.

Under the FAA's regulations, no person may make an intentionally false statement on any application for an airman medical certificate. If an intentionally false statement is made, it will provide the FAA with a basis for revoking all airman, ground instructor, and medical certificates currently held by the person making the false statement. In order for the FAA to prove a violation of this regulation, the FAA must establish three things: 1) that a false statement was made, 2) that the statement was made with knowledge of its falsity, and 3) that the false statement was capable of influencing the FAA's decision on medical eligibility. The FAA must prove that the applicant actually knew that the statement was inaccurate. It is not sufficient for the FAA to prove that the applicant should have known that the statement was false. Actual knowledge

See LEGAL PERSPECTIVE on page 6

Down to Minimums

? Can an airline transport pilot, who has been retired at age 60, be issued a first-class medical certificate?

Whether they are a student with "0" hours or an 80 year old with 3,000 hours, if they meet the requirements for first class certification, then they may be issued a first class medical certificate. ***SV***

? An applicant for third-class medical certification had a left below-the-knee amputation from an accident. He has a prosthesis limb which he plays basketball, dances, and in general, does not defer to his limb. In my opinion, he would have no problem operating the aircraft controls. He is interested in starting flight training. Must he be deferred for further evaluation or can I pass him?

You can issue him a student pilot certificate with the limitation "For Student Pilot Purposes Only" and request on the form 8500-8 that the FAA send paperwork to the FISDO of his choice for him to take a check-ride with an FAA examiner. If he passes this check-ride then he will be issued a SODA, Statement Of Demonstrated Ability. These are given to pilots who have a static disability that is not expected to progress.

SV

? One of my pilots has recently developed diabetes mellitus requiring insulin for control. He has a valid medical certificate that was issued before the disqualifying condition was diagnosed. What regulation invalidates his certificate and where may this pilot find such a reference?

Your pilot may not exercise the privileges of his medical certificate with any medical deficiency that would make him unable to meet the requirements for his current medical certificate. He can reference this in the FAR's Part 61.53. He may however, be able to regain his third class medical certification on insulin if he can meet the stringent FAA requirements.

SV

? Routinely, on first class physicals I have been doing intraocular tension but I am not certain whether the FAA requires this reading for second class. Please let us know the requirements and at what intraocular pressure an AME should deny an airman a medical certificate.

The FAA does not routinely require intraocular tension measurements for any class. In cases of known intraocular hypertension, the FAA requires an initial work-up of this condition including visual fields and intraocular tensions. This work-up is usually done by the treating ophthalmologist and is submitted on FAA Form 8500-14. Periodic evaluations of this sort will be required by the FAA for continued certification.

SV

? I have a patient who has applied for medical certification. He has just been diagnosed with a mild form of epilepsy that is completely controllable on Dilantin. Is there any hope that he can gain certification?

Certainly not any time soon. Both epilepsy (any form) and Dilantin are categorically disqualifying for any class of certification. Applicants who have been seizure-free for ten years and have been off of any seizure medication for seven years could be reviewed for possible certification.

SV

Legal Perspective cont.

may be proved by circumstantial evidence.

The National Transportation Safety Board (NTSB) has had the occasion to review many cases involving FAA allegations that a medical certificate application was falsified by an airman. Knowing how some of these cases were resolved may provide valuable assistance to an AME who is guiding an applicant through the examination process.

When answering the question concerning any current use of medication, an applicant should carefully consider his circumstances. In the Watkins case, an airman failed to disclose on three successive medical applications that he was taking the hypoglycemic drug Orinase. The airman defended against the FAA's falsification charges on the grounds that although he regularly filled the prescriptions for the drug, he had discontinued taking the medication prior to his three consecutive medical certificate applications. The airman reasoned that although the medication was available to him, he did not take the medication, and therefore, his negative answer to the question of current drug use was truthful. The NTSB judge rejected the airman's defense on credibility grounds. The full NTSB upheld this ruling on appeal.

Another recent case illustrates how an airman's analysis of whether an event needed to be reported on his medical application form may not square with how the court later looks at how the question should have been answered. In the Summers case, although the FAA alleged that the airman committed two intentionally false statements, the Court of Appeals agreed with only one of the FAA's charges. Two weeks before applying for a medical certificate from an AME, the airman had been interviewed by a clinical psychologist, who diagnosed the airman with depression. This interview occurred in an attorney's office in connection with obtaining a continuance in an unrelated criminal case involving the airman. The airman did not have any knowledge of the psychologist's diagnosis at the time of the medical application, so the airman answered "no" to #18.m. (mental disorders of any sort: depression, anxiety, etc.). The airman also failed to report this encounter in question #19. ("Visits to Health Professionals in the last three years"). The court determined that the airman did not know that he was suffering from depression because he had not yet been told of the psychologists diagnosis. However, with regard to the visits to health professionals, the court rejected the airman's argument that his meeting with the psychologist was "counseling" that did not need to be reported. Instead, the court found that the airman was being evaluated and tested by a clinical psychologist to determine whether he was fit to participate in a trial, which the airman could not have believed was "merely counseling," thus finding that the airman falsified this answer.

The "knowledge" element of an intentional falsification charge can sometimes pose a challenge for the FAA to prove.

The "knowledge" element of an intentional falsification charge can sometimes pose a challenge to the FAA to prove. If the airman did not actually know of the inaccuracy of the statement at the time the statement was made on the medical application, then the airman will not be found to have made an intentionally false statement. In the Roehr case, an airman answered "no" to any record of other convictions (18w.) The airman was a German citizen who had been convicted years earlier for offenses under German law and who had subsequently moved to the United States. He defended against the FAA's falsification charges on the grounds that he was not obligated to disclose the convictions because a German law provided legal protection against disclosure of convictions that the German government would no longer disclose due to the passage of time. Based on the evidence presented, the NTSB found that the airman knew what information he was required to report, but that instead of answering truthfully, he answered on the basis of what he felt he was legally obligated to report. The NTSB found against the airman, but only after closely scrutinizing what the airman actually knew at the time he answered the question.

See LEGAL PERSPECTIVE on page 7

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CAMA would like to welcome these new members to our growing family of Aeromedical colleagues

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Insert this sheet in your CAMA Membership Directory.
This will keep your directory updated between editions.

Washington Update

★ The FAA Office of Aviation Medicine continues to receive reports of medical events and deaths on major U.S. air carriers. This surveillance mandated by Congress will be completed this summer. It is anticipated that action and possibly an NPRM will be released once all the reports have been received and analyzed.

★ One final report and one initial draft has been issued by the American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE) on Aircraft Cabin Air Quality. In general, the final report indicated there is no evidence that cabin air quality is substandard. However, they do recommend continued inflight studies.

★ Several key positions in the FAA office of Aviation Medicine and CAMI are opening up, including the position of Deputy Federal Air Surgeon. Efforts are now underway to recruit for these positions.

★ Approximately 210 Class III special issuances have been granted for insulin dependent diabetes mellitus. In the group only one was involved in an accident but it was not associated with this airman's diabetic condition or the use of insulin.

★ NASA Administrator, Dan Goldin, has requested the Institute of Medicine to form a committee to study and make recommendations on health care for astronauts during and upon return from space flight. This committee is now being formed and will be comprised of scientists and other experts who will meet in a series of 11 meetings with a report anticipated.

Thanks to Russell Rayman for this update.

SV

Legal Perspective continued

Sometimes, claiming "inadvertence" may help to prove that the airman lacked the knowledge that the answer was false. However, a recent NTSB case suggests that the NTSB may no longer be very tolerant of such excuses. In the Boardman case, the airman explained his false answer to the question concerning a record of other convictions as "borne of haste, not an effort to hide the convictions." The airman explained that he used a previous year's medical application form to guide him to answer yes or no on the current application and that he did not read the questions. The NTSB judge believed the airman. But, on appeal, the full NTSB concluded that the airman tricked the FAA into giving him a medical certificate. The NTSB issued a lengthy admonition:

"The very act of submitting a medical certificate application invites reliance by the FAA on the responses it contains, and the nature of the responses, every airman can be fairly presumed to appreciate, dictates whether the certificate will be issued. It seems to us that an airman who, knowing this, tenders an application that turns out to have a wrong answer to one or more of many questions he freely chose not even to read, much less to thoughtfully answer, cannot reasonably argue that he lacked the intent to give false information, for the submission of inaccurate information is a natural and foreseeable consequence of completing an application in a manner that essentially guarantees its unreliability. We think that such an airman, having acted in a manner that could be viewed as evincing a willful disregard of the truth or falsity of the information officially submitted and, therefore, in a way reflecting contempt for the airman medical certification process, should be determined to have intended that whatever answer he gave be utilized in the review of his qualifications."

PART II will appear in the next "FLIGHTPHYSICIAN" Kathleen Yodice is an attorney with Yodice Associates, a firm well known for its expertise in aviation law. She was formerly with the FAA's Legal Department. Kathleen is a frequent speaker at aeromedical seminars. She is a member of the CAMA Board of Trustees and serves as CAMA's legal advisor.

From the SI Files

Myocardial Infarction in Airmen

Earl F. Beard, M.D., F.A.C.C., F.S.C.A.I.

A myocardial infarction in an airman can be an extremely dramatic and important event. It may certainly endanger his life and health but also importantly, his career and avocation. Outcomes of treatment become extremely important in this regard. We will review options in the treatment of myocardial infarction, assessment of the patient who has had an event and assessment for airmen certification.

This paper is not intended to be a listing of the very important multicenter studies showing that one particular modality is superior to others in the hands and institutions of the investigators. We will use data from some of these only to make certain points. Instead, we will approach our options in treatment from the standpoint of assessing a patient in the emergency room and trying to make the best decisions possible. We will emphasize general principals. In the pre-coronary care unit era, treatment was mainly observation and watchful expectancy. When methods of defibrillation became available and the importance of arrhythmia recognized, we attempted to treat such in coronary care units. Current emphasis is on all these principals plus re-vascularization to save as much myocardium as possible. There are several important general principals;

- Myocardial infarction is not a single entity, but a heterogeneous group of diseases. It does not take much imagination to see that a small inferior infarct from occlusion of a distal right coronary artery branch in an otherwise healthy heart is far different from a massive anterior infarct and cardiogenic shock, perhaps with other complicating co-morbidity's.

- Treatments should be tailored to the situation and not necessarily what author has shown as best in his hands or in a certain setting.

- Intervention to attempt re-vascularization should be done as early as possible.

- In general, it is probably best to get the infarct patient to a catheterization laboratory early so that you know what the anatomy is and are not treating blindly.

- Decisions should be made quickly on assessment, but they must remain flexible and responsive to any changes in the clinical course.

In infarcts over 48 hours old treatment options are fairly limited. Even considering all the ramifications of the open vessel hypothesis most stable patients in this category will be managed by conventional treatment. By conventional, we mean essentially non-thrombolytic, non-angioplastic treatment to include observation in the coronary care unit. These include: platelet suppressants, beta blockers and angiotensin-converting enzyme inhibitors and glycoprotein IIb, IIIa inhibitors with the reduction agents and actual put into the 3-A inhibitors. The lipid reduction agents help stabilize plaques by lipid extraction so that the fibrinous cap does not rupture and cause further platelet aggregation and thrombosis. The SAVE study has shown a deduction in mortality and better outcomes by obtaining favorable types of ventricular remodeling in patients with depressed ejection fractions. On some indications, for example, continuing or recurring pain, extension of infarct, stuttering infarct, developing shock, patients with older infarct should probably go to the catheterization laboratory or even get systemic thrombolysis if no catheterization laboratory is available.

It is in the fresh myocardial infarct that we have more opportunity to save myocardium by revascularization from thrombolysis or angioplasty. We, at the Texas

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Myocardial continued

Heart Institute were among the first to recognize the value of direct angioplasty in removing both thrombus and underlying stenosis and subsequently several studies have shown distinct advantage where direct angioplasty is feasible. Glycoprotein IIb and IIIa inhibitors have even further enhanced the efficacy of direct angioplasty. Myocardial infarctions associated with cardiogenic shock must be taken to the catheterization laboratory for direct angioplasty where possible. The expected mortality of 90% in cardiogenic shock can be reduced to approximately 50%. So far as thrombolytic agents are concerned, one has little reason to doubt there is a fairly high initial success rates with thrombolytic agents. However, in our practice, where post-thrombolytic treatment with heparin is quite well controlled, we see open vessels only about half of the time at the time of cardiac catheterization. Many multi-center trials have compared efficacy of various thrombolytic agents with most differences favoring the TPA or RTPA families. There have been reports of some unusual agents, i.e. large doses of heparin alone, with results not terribly different and bleeding rates similar to the more conventional agents. There has also been some interesting reports using glycoprotein IIb, IIIa agents without angioplasty.

At the Texas Heart Institute we now do several things different in angioplasties for acute myocardial infarction:

1. We do not hesitate to go to a catheterization laboratory and do angioplasty at any time after TPA, whereas former teaching was to wait forty-eight hours for fear of hemorrhage into the arterial wall and into the infarct. We do reduce the dose of ReoPro or avoid it under many situations.

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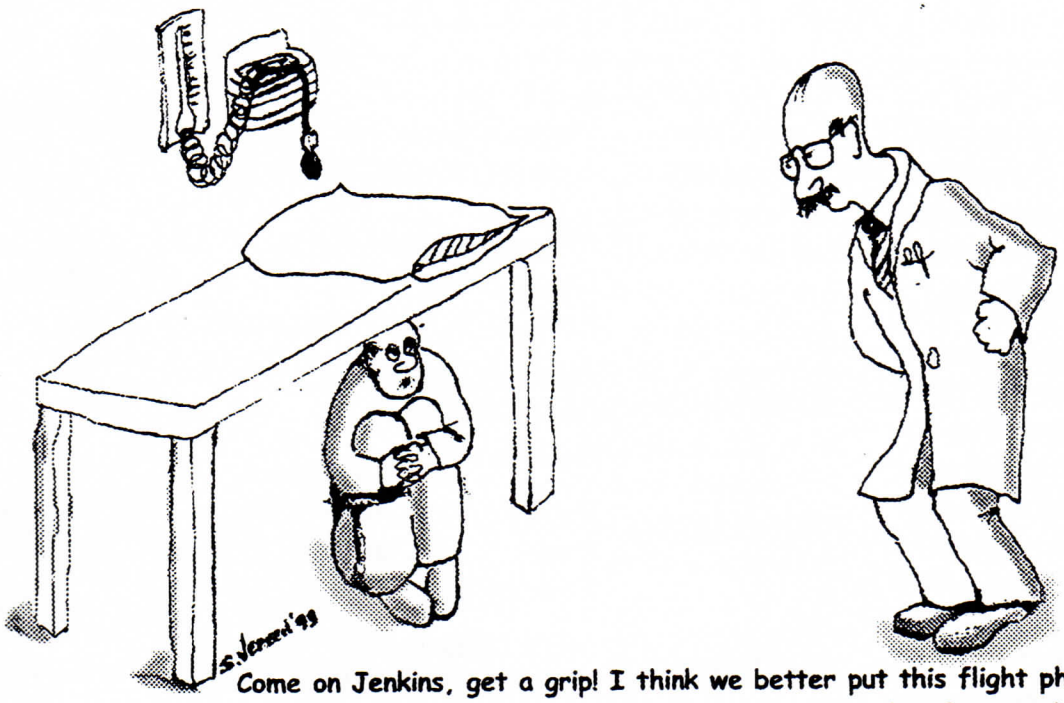

Come on Jenkins, get a grip! I think we better put this flight physical on hold and work on your morbid fear of heights for a bit!

Myocardial continued

2. We do not hesitate to stent where there has been a thrombus load and stent the majority of cases.

3. We do not hesitate to do other vessels besides the culprit vessel at the same setting if all goes well, feeling that more complete re-vascularization improves outcomes.

4. Since in-stent stenosis is an ongoing problem and perfusion scans remain abnormal after myocardial infarction has occurred, we try to do follow-up arteriography at three to four months to detect re-stenosis and treat it. The FAA guidelines specifies a six months waiting period.

5. We try to avoid surgery in acute infarct cases, because mortality rates in these cases remains high (up to 20 to 30th %). Therefore, the failed angioplasty may have been a recent myocardial infarction.

6. We use intraaortic balloon pumping at the slightest indication during antioplasty.

At our institution approximately 20 to 30 percent of acute myocardial infarctions are treated by direct angioplasty and approximately 30 percent have thrombolysis with the remaining one-third having either conventional or combinations of treatment.

In considering special issuance medical certificates for acute myocardial infarctions in the United States by the FAA and Federal Air Surgeons Consultants panel, there are certain guidelines for consideration of airmen and these are outlined in the FAA Aviation Medical Examiners guide. Since there is wide variability in myocardial infarctions, and in the patient having them, issuance may be considered after a period of six months stability following a myocardial assessment, treadmill stress testing, and laboratory studies with special emphasis on lipids. In general, it is wise to have a perfusion exercise or perfusion scan or stress echocardiogram for such an evaluation and for later comparison. Class I and Class II certificates by special issuance usually require all of these studies and assessments plus postoperative

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CAMA CONSULTANTS

*To our new members and as a reminder to all: This is a list of more experienced AME's that have volunteered to help with troublesome certification cases. For involved questions, e-mail or fax is preferred. This list is **NOT** for use by airmen, but solely for AME's within the CAMA membership.*

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Myocardial continued

coronary arteriography. Favorable features for consideration in an airman certificate in the post myocardial infarction patient include good left ventricular function, no significant arrhythmia, no myocardium left in jeopardy, the infarct vessels are open or are supplying scar only, adequate revascularization, good risk factor control including a willingness on the part of the airman to actively participate in reducing his modifiable risk factors.

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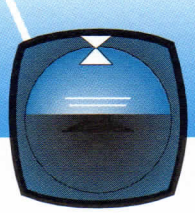

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